

Please read the instructions & guidelines on overleaf before filling the form

1. Card Holder's Name: (exactly as printed on the card)		2. Daman Card No:		
3. Reason for not using Daman listed Healthcare facilities (kindly indicate)				
<input type="checkbox"/> Emergency <input type="checkbox"/> Family Doctor <input type="checkbox"/> Preferred Personal Choice <input type="checkbox"/> Service not available <input type="checkbox"/> On vacation/business trip outside UAE <input type="checkbox"/> Other(s) please specify				
4. Name & Address of the Hospital / Clinic (refer to instructions at the back)	Bill No.	Treatment Date	Description of Services (refer to instructions at the back)	Amount
.....				
.....				
.....				
.....				
.....				
.....				
Currency (if treatment availed outside UAE).....				TOTAL
5. Declaration				
<p>I, the undersigned, declare that the information above is correct and that reimbursement requested is for expenses paid by me for the treatment of my covered condition. And I hereby authorize Daman to pay the eligible expenses directly to the policy holder and in local currency (AED).</p> <p>I hereby authorize any Doctor, Hospital, Clinic or Medical Provider, any Insurance Company or any other Company, Institution or any other person who has any record or information about me and / or any of my family members to provide National Health Insurance Company – Daman with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization or any other information required by Daman.</p> <p>I am fully aware that any person who intentionally makes any false and/or misleading statement and/or information to obtain reimbursement from Daman is subject to penalization.</p>				
..... Name Signature Date Contact No. Relationship to the Card Holder

6. Medical Information (To be filled by treating Doctor for all outpatient treatment. For cases like hospitalization, procedures , surgeries-detailed Medical report is required)	
Medical History / Chief Complaints:	Diagnosis:
Treatment Details:	Visit Date:
<p>I declare that I have attended to this patient and that the particulars given are best of my knowledge true and correct.</p> <p>Name & Signature of the Doctor: Date: Stamp:</p>	
7. Employer's Section (To be attested by HR Dept / Insurance coordinator)	
<p>Is the above case work related? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please Specify).....</p> <p>Cheque payment is to be collected by : <input type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> Other (Specify).....</p> <p>Name & Signature: Date: Stamp: Ref. No.....</p>	

General Instructions

1. This form can be used for all types of medical plans. This form needs to be completed by the insured member (Card holder), only if the provider is not submitting the claim on his behalf.
In case of liability by another party e.g. other insurance company / company / individual etc, claim should not be submitted to Daman. (Please provide details)
2. Please read the form carefully and make sure to complete all pertinent information. Daman will not be able to process any incomplete Reimbursement Claim Form with lacking proper documentation. (Listed below)
3. Use a separate form for each Daman Member. A new form can be downloaded from www.damanhealth.ae or obtained from the Customer Service Desk in any of Daman's branches.
4. For fast processing, please submit the following documents along with your duly filled Reimbursement Claim Form.
Essential documents:
 - Original itemized bill / Invoices with date.
 - Original prescription for medication given by the treating doctor.
 - Investigation results/reports like laboratory tests, x-rays, etc, for procedures above than AED 1000.**Additional requirements to above:**
For Inpatient (Hospitalization Cases)
 - Medical Report / Discharge Summary stamped & signed by the treating Doctor.**For treatment availed Outside the UAE**
 - Copy of passport showing Exit & Re-entry to UAE or any other similar documents (E.g.: E-gate) for inpatient (hospitalization cases) and / or whenever necessary.
5. Please retain copies of receipts and documents enclosed with your claim, as Daman will not return the original documents.
6. All claims subject to reimbursement should be submitted to Daman from the last treatment date as mentioned below:
 - a. Within 60 Days if service taken within UAE and outside the network
 - b. Within 90 Days if service taken outside UAE and outside the network
7. To ensure smoother & prompt settlement of your claims, please submit all the above required documents directly to Customer Service Desk in any of Daman branches as convenient.

If you have any questions or need assistance in filling this form,
Please call **800 4 32626** within UAE or **+971 2 6149555** Outside UAE

Instructions to fill the Form

- 1&2. Please write your name & Daman Card Number as mentioned in the Daman Card.
3. Please indicate the reason/s for not using Daman card in any of Daman listed healthcare facilities. This information is important in determining the coverage of your insurance policy.
4. Provider Name & Address – Kindly use more than one line if necessary to provide this information about each facility where you were treated.

Bill No. - Please write the serial number/reference number printed on the bill / receipt / invoice for each service separately.
Service Date – Kindly write start date of treatment for each service against each bill.
Description of Services – Kindly mention type of service like Consultation /Pharmacy / Investigations / Physiotherapy/ Dental / Hospitalization.

Amount – Kindly mention the exact amount as appears on the invoices.
Total – Total amount of all the invoices submitted with this form for reimbursement from Daman.
Currency – Name of the currency in which actual payment was made.
5. Declaration – Kindly write your name, signature, date, the contact number and relationship to the cardholder.
6. Medical Information – Request your treating doctor to fill up brief medical information about your condition and treatment.
7. Employer Section –Kindly indicate who will be authorized to collect the cheque for this reimbursement.